



820 N.W. 13th Street • Oklahoma City, OK 73106 • Phone (405)943-0303 • Fax (405)272-0515

Confidential Patient Information

Please invest a few moments to answer these questions so the Doctor can help you get better faster.

PATIENT INFORMATION:

Name: _____ Date: _____

Sex: M or F Date of Birth: _____

Marital Status: S M D W Age: _____

Home Phone: () ____ - ____ Email: _____

Cell Phone: () ____ - ____ SSN: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: () ____ - ____

SPOUSE INFORMATION:

Name: _____ DOB: _____

Employer: _____ SSN: _____ - _____ - _____

Physician's Name: _____ Phone #: () ____ - ____

REFERRAL INFORMATION:

Attorney 1140 AM {KVSP} 105.7 FM

Friend Former Patient Relative

Postcard Phone Book Other

Referred By Name: _____ Phone: () ____ - ____

Address: _____ City: _____ ST: _____ Zip _____

EMERGENCY CONTACT PERSON:

Name of person to contact: _____

Address of person: _____

Phone # 1: _____ Cell #: _____

Relationship to Patient: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, whether or not my insurance company contributes. I hereby authorize the doctors at the Pro-Chiropractic Inc. dba The Brooks Clinic and whomever they may designate as their assistants to administer care as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or care. I certify that the information in this entire intake form is true and correct. By signing below I also acknowledge receipt of the privacy practices of this office.

Patient's (Parent or Guardian's) Signature

Date

If you have insurance please provide your ID Card when you return this form to the receptionist. As a courtesy we will file your insurance for you.

We look forward to serving you!